December 28, 2005

Ms. LouEllen Rice, Grants Management Officer
Division of Grants Management, OPS
SAMHSA
One Choke Cherry Road
Rockville, MD 20857

Dear Ms. Rice:

Please find below the Modifications to Washington State's 2006 Mental Health Block Grant Plan as requested by the Peer Review Panel on December 8, 2005, in Portland, Oregon. If this additional information does not meet your expectations or you have further questions you are invited to please contact Amy Besel, the State Planner, by phone at (360) 902-0202 or by email at BeselAJ@dshs.wa.gov.

List of Modifications to the FY 2006 ADULT Plan

ISSUE:

#1) Within 30 days, the State shall submit to CMHS a plan to ensure representation from the State's social service agency on the MHPAC.

RESPONSE:

The State and the MHPAC were not aware that a representative from TANF was required on the MHPAC. As the TANF program is administered under the Economic Services Administration (ESA), the MHPAC is issuing an invitation to the director of ESA, Deb Marley, requesting appointment of a staff person to the MHPAC. As staffing resources continue to be problematic throughout the Department of Social and Health Services (DSHS) we expect it may take several months to fill this request. We are, however, pursuing it in good faith with diligence.

The MHPAC does have representation from Medical Assistance, who oversees the State's managed care benefit called Healthy Options, which covers a wide array of Medicaid Services.

ISSUE:

#2) Within 30 days, the State shall submit to CMHS a description of health services for persons with SMI.

RESPONSE:

Washington State continues to seek creative solutions to providing comprehensive medical services to all of our state's citizens. For the recipients of the public mental health system, this is usually through the base of community physicians who accept Medicaid for payment. There are also several community clinics that provide service on a sliding scale basis, for persons with limited resources. Case managers at the Community Mental Health Care Agency (CMHA) level, work with their respective consumers' Primary Care Physicians (PCP) to ensure physical issues are addressed.

While considerably more needs to be done to improve the provision of health services to consumers with SMI, the state has implemented several strategies to address the over-arching access issue. For example, there are carve-out pilot programs in both Pierce County and King County that were developed to integrate primary care and substance abuse treatment. MHD's contracts with the Regional Support Networks (RSN's) and the Healthy Options Plans requires working agreements between these entities at the local level, detailing how they will coordinate care.

Effective January 2005, a pilot project was initiated called the Washington Medicaid Integration Project (WMIP). Through this project, DSHS has contracted with Molina Healthcare of Washington, Inc. (Molina) to manage and provide medical and chemical dependency services through Molina's provider network, with an initial enrollment of 6,000 individuals in a county north of Seattle. The focus of this new project is to make available a care coordination model, which is a team of care coordinators who will work with the clients to help identify health issues early, help coordinate services, and help the client follow-through with prescribed treatment. Coordination of these services is expected to accomplish the following:

- Prevent unnecessary hospitalizations;
- Postpone placement in nursing homes;
- Eliminate duplicate prescriptions; and
- Prevent the use of emergency rooms for treating conditions that are more appropriately addressed in physicians' offices.

Outpatient mental health services were added in October and are provided through Molina's approved network of providers consisting of licensed community mental health agencies. Together, all participants in WMIP are working to streamline and enhance the quality of care for Medicaid recipients enrolled in the pilot.

ISSUE:

#3) Within 30 days, the State shall submit to CMHS all required data regarding the Criterion 1 NOM: Reduce Utilization of Psychiatric Inpatient Beds with 180 days.

RESPONSE:

Goal 2: Reduce Utilization of Psychiatric Inpatient Beds – Adult

Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings.

Objective 1: Reduce unnecessary hospitalization

Performance Indicator: Regional Support Networks will maintain a percentage of adult outpatient clients who were not hospitalized at a rate over 80%.

(The number of adults (18-59) who received community outpatient services in a given FY who were not hospitalized at any time in that FY *over* the number of people who received community outpatient services in the same given FY)

2004: 93.7 % (Achieved) 12,742/ 131,037
2005: Not available at this time
2006: 94.0% (Planned)

Performance Indicator: Maintain a utilization rate of under 25 days per 1,000 population for clients admitted to community hospitals and freestanding evaluation and treatment facilities**.**

(The number of inpatient days –Community Hospital and Evaluation and Treatment Center- in the given FY *over* the number of people in the Washington State population in the same given FY X 100)

2004: 21.6 days per 1,000 population (Achieved) 133,225/ 6,167.800 X 100
2005: Not available at this time
2006: 21.0 days per 1,000 population (Planned)

Performance Indicator: Maintain a statewide rate of adults served in state hospitals not greater than 0.7 per 1,000 general population.

(The number of people (18-59) served in state hospitals in a given FY *over* the number of people (18-59) in the Washington State population in the same given FY X 100)

2004: 0.5 per 1,000 population (Achieved) 2,109/ 3,687,048 X 100
2005: Not available at this time
2006: 0.5 per 1,000 population (Planned)

Table 21. Profile of Non-Forensic (Voluntary and Civil-Involuntary Patients) Readmission to Any Psychiatric Inpatient Care Unit (State Operated or Other Psychiatric Inpatient Unit) Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 21.					
Report Year:	**2005**				
State Identifier:	WA				
	Total number of Discharges in Year	**Number of Readmissions to ANY Psychiatric Inpatient Care Unit Hospital within**		**Percent Readmitted**	
		30 days	**180 days**	**30 days**	**180 days**
TOTAL	12586	807	3108	0.06411886	0.24694105
Age					
0-3	3	0	1	0.00%	33.33%
4-12	226	2	26	0.88%	11.50%
13-17	655	25	133	3.82%	20.31%
18-20	539	30	134	5.57%	24.86%
21-64	10667	736	2759	6.90%	25.86%
65-74	262	12	38	4.58%	14.50%
75+	225	1	14	0.44%	6.22%
Not Available	9	1	3	11.11%	33.33%
Gender					
Female	6078	409	1515	6.73%	24.93%
Male	6492	393	1585	6.05%	24.41%
Gender Not Available	16	5	8	31.25%	50.00%
Race					
American Indian/ Alaska Native	271	10	67	3.69%	24.72%
Asian	329	19	89	5.78%	27.05%
Black/African American	1026	113	308	11.01%	30.02%
Hawaiian/Pacific Islander	25	0	6	0.00%	24.00%
White	8238	540	2165	6.55%	26.28%
Hispanic*					
More than one race	502	54	147	10.76%	29.28%
Race Not Available	2195	71	326	3.23%	14.85%

Hispanic/Latino Origin					
Hispanic/Latino Origin	558	34	131	6.09%	23.48%
Non Hispanic/Latino	8552	646	2341	7.55%	27.37%
Hispanic/Latino Origin Not Available	3476	127	636	3.65%	18.30%

1. Does this table include readmission from state psychiatric hospitals? ☑ Yes ☐ No

2. Are Forensic Patients Included? ☐ Yes ☑ No

Comments on Data: Includes state hospital and CLIP facilities, evaluation and treatment centers, and community hospitals.

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

ISSUE:

#4) Within 30 days, the State shall submit to CMHS numerators and denominators for the Criterion 2 NOM: Increased Access to Services.

RESPONSE:

Goal 1 Increase Access to Services - Adult

Individuals have access to a system of comprehensive and integrated community based services.

Objective 1: Increase access to services for adults

Performance Indicator: Regional Support Networks will maintain a statewide penetration rate of at least 1.5 % for adults who received publicly funded outpatient mental health services**. (Basic Table 2a)**

(The number of adults (18-59) who received community outpatient services *over* the number of adults (18-59) who resided in the state for a given FY)

2004: 2.1% (Achieved) 76,308/ 3,564,795
2005: Not available at this time
2006: 2.3% (Planned)

Objective 2: Provide seamless discharge from inpatient services

***Performance Indicator*:** Regional Support Networks will maintain a percentage of clients over 30% who received outpatient services within 30 days after being discharged from the state hospital, community hospital, or freestanding evaluation and treatment facility.

(The number of people who were discharged from a state or community hospital or Evaluation and Treatment Center who were seen in outpatient services in given FY 30 days following discharge *over* the number of people discharged in given FY.)

2004: 55.8 % (Achieved) 7,452/ 13,357
2005: Not available at this time
2006: 55.5% (Planned)

Objective 3: Increase access to services for American Indians

Performance Indicator: Maintain a statewide penetration rate of at least 2% for American Indian persons who received publicly funded outpatient mental health services. **(Basic Table 2a)**

(The number of American Indian people who received outpatient mental health services in given FY *over* the number of people in the general American Indian population in given FY.)

2004: 4.2 % (Achieved) 3,785/ 92,053
2005: Not available at this time
2006: 4.5% (Planned)

Objective 4: Increase access to services for ethnic minorities

Performance Indicator: Maintain a statewide penetration rate of at least 1.5% for ethnic minority persons who received publicly funded outpatient mental health services**. (Basic Table 2a)**

(The number of minority people who received outpatient mental health services in given FY *over* the number of minority people in the general Washington State population in given FY.)

2004: 2.9 % (Achieved) 39,943/ 1,358,825
2005: Not available at this time
2006: 2.3% (Planned)

Objective 5: Increase access to services for older adults

Performance Indicator: Regional Support Networks will maintain the proportion of older adults (60+ years) who received publicly funded outpatient mental health services at a rate greater than 1% of the general population. **(Basic Table 2a)**

(The number of people 60 + years who received outpatient mental health services in given FY *over* the number of people 60 + years in the general Washington State population in given FY.)

2004: 1.3 % (Achieved) 12,855/ 958,681

2005: Not available at this time
2006: 1.5% (Planned)

Objective 8: Increase access to services for adults with a developmental disability

Performance Indicator: Serve at least 3,000 persons with both a mental illness and a developmental disability in outpatient settings. .

(The number of people with a developmental disability who received outpatient mental health services in given FY *over* the number of people who received outpatient services in given FY.)

2004: 5,567 persons or 4.2 % of persons served (Achieved) 5,567/ 131,037
2005: Not available at this time
2006: 3,700 (Planned)

Objective 9: Increase access to services for adults with a sensory impairment

Performance Indicator: Serve at least 1,000 persons with both a mental illness and a sensory impairment in outpatient settings.

(The number of people with a hearing or vision impairment who received outpatient mental health services in given FY *over* the number of people who received outpatient mental health services in given FY.)

2004: 2645, or 2.0 % of persons serviced (Achieved) 2645/ 131,037
2005: Not available at this time

Objective 10: Increase access to medical services

Performance Indicator: Maintain a percentage of at least 70% of adult consumers who saw a nurse or doctor in the past year for a health check up or because they were sick.

(The number of people with who responded "yes" on item #4 of the adult MHSIP Survey *over* the number of adults who completed the MHSIP Survey in a given FY)

2004: 88.9 %
2005: Not available at this time
2006: 89.0 % (Planned)

ISSUE:

#5) Within 30 days, the State shall submit to CMHS a description of the State's financial and staffing resources.

RESPONSE:

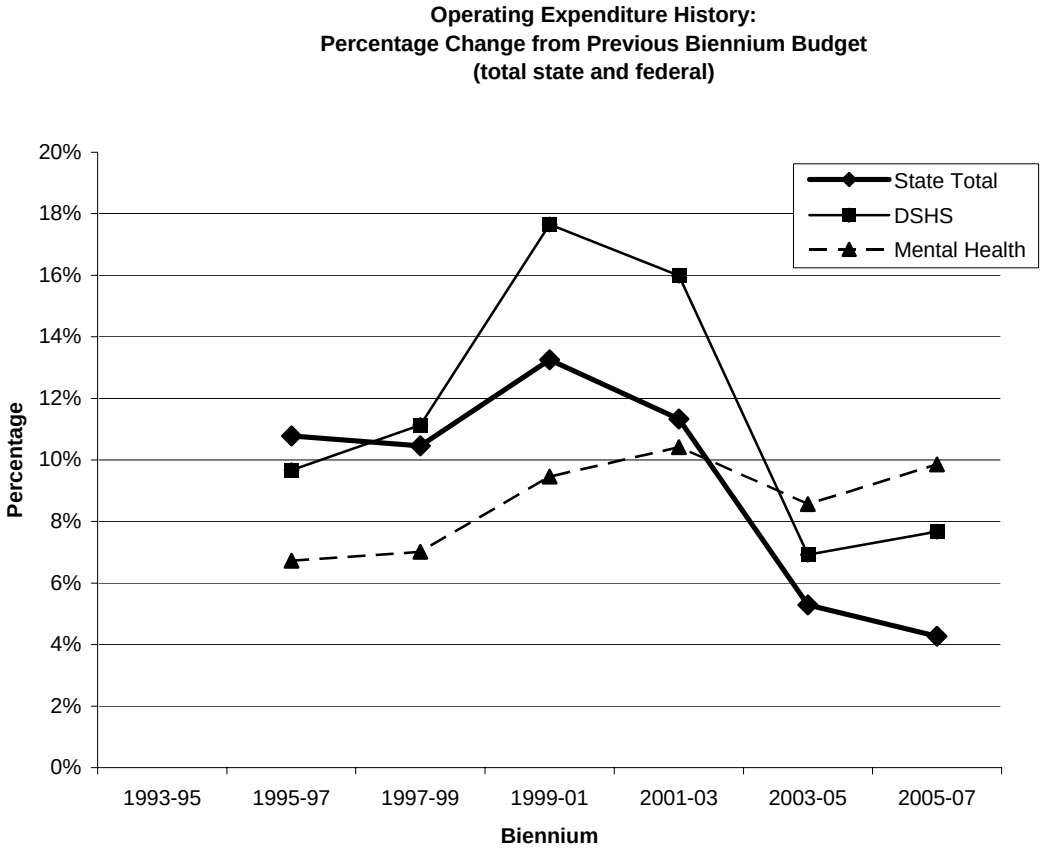
The MHD employees approximately 65 persons at headquarters and nearly1,700 persons at the state hospitals.

In the mid-1990s, Washington was granted a Medicaid 1915b waiver through the Federal Health Care Financing Administration (HCFA), now CMS. The waiver permits the State to purchase both outpatient and inpatient mental health services through PIHPs administered by RSNs. The amount of funding allocated to each RSN is determined by a capitated formula. This formula was originally based primarily on Medicaid-eligible individuals, but, under a planned transition, the formula has been shifting to give greater consideration to mental illness prevalence factors.

Thus MHD is currently responsible for the administration of a statewide integrated managed mental healthcare program. In FY03, this included community mental health services to 126,867 individuals, with almost 30 percent of those served being children under the age of 18. During that period, community inpatient psychiatric services were provided to 8,444 individuals.

Washington utilizes a 2-year budget, with the beginning of the biennium's first fiscal year starting on July 1 of odd-numbered years. In April 2005, the Washington Legislature approved a FY06-07 biennium State budget totaling over $49 billion, with over $17 billion (more than a third) allocated to DSHS. Of the DSHS budget, MHD's biennium budget was established at $1.3 billion (approximately $686 million per year), or about 8 percent of the DSHS budget.

A review of the past several biennium budgets reveals that, since the 1993-95 biennium, the State's operational budget has increased by 69 percent, the DSHS budget by 90 percent, and the MHD budget by 60 percent. As shown in the graph below, relative to State and DSHS budgets, MHD has fared better in more recent budgets in terms of percentage increase from the budget level of the previous biennium.



Source: data from the Legislative Evaluation and Accountability Program Committee, http://leap.leg.wa.gov/leap/oversight/index_finalh.asp; http://leap.leg.wa.gov/leap/Budget/detail/2005/o0507f.asp).

ISSUE:

#6) Within 30 days, the State shall submit to CMHS a description of the use of $1.5 million in block grant funds allocated for "other grant activities".

RESPONSE:

Of the estimated 8.4 million dollars awarded to Washington State, 5% (grant limit) stays at MHD for administrative costs. Of the *remaining* 95%, Washington Administrative Code requires 80% to be distributed to the RSNs. The other 20% (approximately 1.5 million) is utilized by MHD for selected activities. In determining which initiatives would be funded this year, MHD developed the following list of guiding principals against which all proposals would be measured. To be funded as part of the 20%, activities must:

1. Be in concert with the National Outcome Measures and fall within the parameters of the MHBG assurances and requirements;

2. Work in tandem with the Division's Strategic Plan which, has been updated in collaboration with the MHPAC to incorporate the ideals of "Achieving the Promise: Transforming Mental Health Care in America";

3. Hold meaningful and measurable outcomes that are in line with articulated consumer/family voice;

4. Link well to other resources and transformation activities;

5. Meet needs in the system that are not fulfilled elsewhere, allowing for minimal negative impact on other service agencies if funding is not approved; and

6. Align well with other Division initiatives or legislatively mandated expectations.

This year's "20%" is focused supporting the following areas:

- **Consumer, advocate, and family voice** driven and promoted activities
- **Vocational** initiatives that lead to meaningful employment
- **Residential** resources that promote safe and affordable housing
- **Tribal** supports that improve infrastructure and services to tribal communities
- **MHPAC** resources that ensure consumer participation continues to increase and that state-wide diversity is represented
- **Data Development** to validate success our areas for improvement

The primary ways in which these focused areas will be supported include:

- **Conferences** such as those for co-occurring disorders, behavioral healthcare, foster care, early intervention, ethic minorities, and youth/parent advocacy.
- **Trainings** for issues or populations such as disasters, assisting consumer's in applying for Medicaid, increasing housing access, implementation of evidence–based practices, targeted trainings for geriatric specialists, ethnic minority specialist, chemical dependency specialists, older adults, ombuds, and peer support counselors.
- **Research and data collection** on such things as evidence–based practices, consumer satisfaction, club houses, and co-occurring disorders.

STATE DESIGNEE:_____DATE:_____
Amy Besel, Program Manager/Block Grant Planner

MHPAC DESIGNEE:_____DATE:_____
Joann Freimund, Chair MHPAC

List of Modifications to the FY 2006 CHILD Plan

ISSUE:

#1) Within 30 days, the State shall submit to CMHS a description of health, medical and dental, housing/residential, educational, substance abuse, and case management services for children with SED.

RESPONSE:

Public mental health services are provided to children under the same Regional Support Network managed care system. These services for children are integrated throughout the mental health system and allied system of care and are available statewide. The RSNs are responsible for coordinating the care of adolescents served by multiple systems such as substance abuse, developmental disabilities, juvenile corrections, child welfare, Medicaid-funded healthcare, and the schools. The RSNs and their providers utilize multidisciplinary teams to coordinate care. These teams are also utilized to provide discharge planning for children who are in inpatient settings and juvenile detention centers.

The needs of all children and families are complex and ever changing. Over the years, many specialized systems including juvenile justice, child welfare, substance abuse, special education and mental health have evolved in an effort to respond to those needs. The services developed by these various systems are pre-designed to meet the needs of a typical child when, in fact, they must increasingly serve children and families with unique needs.

The Mental Health Division will continue to encourage other child-serving agencies within DSHS to recognize children as "our state's children" and will continue to discuss and find ways to eliminate the barriers to sharing information and data. Mental Health Division continues to encourage other state agencies such as schools and health departments to break down all barriers and to share data whenever possible to better serve the needs of children and their families.

For physical health care services, children have access through community providers who accept Medicaid and welfare (called General Assistance to the Unemployable- GAU). Additionally, there are also several community clinics that provide service on a sliding scale basis, for children of families with limited resources. The Governor, Christine Gregoire, has embarked on an effort to ensure every child in Washington State has healthcare coverage by 2010.

As noted in the ADULT section, # 1, above, there are several other initiatives and carve-outs within the state aimed at increasing access to quality medical and dental care.

Housing and residential needs persist across all ages, ethnicities, etc. While it is preferable to serve children in their homes within the structure of their natural supports, sometimes children require the specialized care of inpatient services at the State Hospital's Child Study and Treatment Center (CSTC) or one of the Children's Long-term Inpatient Care (CLIP) facilities. Screening and referral protocols are in place for these services. This year, the CLIP facilities are directly contracting for services with the MHD, which increases the amount of money available for services by taking out the administrative fees of the RSNs.

In addition to the services funded by MHD and other state agencies for the provision of system-wide services to children, the Mental Health Division funds mental health parent programs such as the Parent Community Connector project and the Parent Council which provides an essential link in the continuum of care that is often overlooked by formal systems. Parents have developed ways to survive the day to day stresses of caring for a special-needs child/youth. The Community Connectors and the Parent Council, allows for parents to help other parents who find themselves in a similar situation. These "other" parents must have children, grandchildren or foster children with complex needs and be willing to network within their community.

Many efforts have been made to improve the continuum of services to children across all social and health services. In 2002, the Department of Social and Health Services formed a workgroup known as, "The Select Committee on Adolescents in Need of Long Term Placement' ("the Committee"), to examine the continuum of care and the sufficiency of services and housing options for youth with the most complex needs. The Committee has published a report that details the current status of services available for these children and makes strong recommendations for sweeping systems change, including adoption of Evidence Based Practices.

A DSHS Children's Mental Health Services Workgroup was convened in December 2003 by the DSHS Assistant Secretaries for the Children's Administration, the Juvenile Rehabilitation Administration, and the Health and Rehabilitative Services Administration, of which the MHD was a division. The Workgroup had thirty members, ten connected with each Administration, including field staff, providers, parents, foster parents, researchers, advisory board members, advocates, DSHS partners and other state agencies, meeting bimonthly through June. A report was presented to the three Assistant Secretaries at the end of July 2004 with recommendations for the improvement of mental health services and how they are delivered by DSHS. A SAMHSA System Improvement Grant was submitted to assist in the implementation of these reform efforts, but was not awarded.

As a result of this work group, and under the direction of the three DSHS assistant secretaries, the Children's Mental Health Initiative was born. As described above, this collaborative effort between the Mental Health Division, the Juvenile Rehabilitation Administration and the Children's Administration was formed to decrease duplication and increase resource management in an effort to provide more comprehensive services to children with SED and multi-system involvement.

One recent accomplishment of this group was the delivery of a report in February 2005 to the three DSHS secretaries, providing valuable research on evidenced based practices (EBPs) for children. In turn, five EBPs have been selected for broad implementation throughout all three systems. They include:

- Multi-dimensional Treatment Foster Care (MTFC);
- Functional Family Therapy (FFT);
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT);
- Family Integrated Therapy (FIT); and
- Multi-systemic Therapy (MST).

Implementation and delivery of services based on these EBPs are expected to generate treatment outcomes for children, youth and families which will hopefully result in placement stability, improved educational achievements, reduced out of home placements, reduced use of restrictive treatment options and overall improved quality of life and enhanced resiliency. The initiative will target implementation efforts by focusing on workforce development. By supporting specialized training and certification for clinicians, significant work force enhancement can be achieved without disruption to usual funding levels and service priorities. A comprehensive implementation plan has been developed for each EBP with anticipated completion by the end of the biennium.

Another strength of Washington's mental health system for children, is a joint project initiated by MHD with the Office of the Superintendent of Public Instruction. The goal of this endeavor is the identification of promising programs where public schools and public mental health providers may collaborate effectively. A report was subsequently submitted to the legislature in June of last year identifying 25 exemplary programs. Interviews and further information gathering took place last fall. Information about the promising practices identified will be disseminated through the public schools and public mental health systems within the coming months.

ISSUE:

#2) Within 30 days, the State shall submit to CMHS all required data regarding the Criterion 1 NOM: Reduce Utilization of Psychiatric Inpatient Beds with 180 days.

RESPONSE:

Goal 2: Reduce Utilization of Psychiatric Inpatient Beds - Children

Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings.

Objective 1: Increase community-based services

Performance Indicator: Regional Support Networks will maintain a percentage of outpatient children and youth who were not hospitalized at a rate over 80 %.

(The number of children/youth (0-17) who received community outpatient mental health services in given FY who were not hospitalized in the FY *over* the number of children/youth (0-17) who received mental health outpatient services in the same given FY)

2004: 97.9% (Achieved) 38,815/ 39,014
2005: Not available at this time
2006: 98.0% (Planned)

Performance Indicator: Regional Support Networks will maintain a utilization rate of under 20 days per 1,000 population for children and youth admitted to a community inpatient setting.

(The number of inpatient days –Community Hospital and Evaluation and Treatment Center - for children/youth (0-17) in given FY *over* the number of children/youth (0-17) in Washington State general population X 100

2004: 12.5 days 1,000 population (Achieved) 19,052/ 1,522,071 X 100
2005: Not available at this time
2006: 13.1 days per 1,000 population (Planned)

Table 21. Profile of Non-Forensic (Voluntary and Civil-Involuntary Patients) Readmission to Any Psychiatric Inpatient Care Unit (State Operated or Other Psychiatric Inpatient Unit) Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 21.					
Report Year:	**2005**				
State Identifier:	WA				
	Total number of Discharges in Year	**Number of Readmissions to ANY Psychiatric Inpatient Care Unit Hospital within**		**Percent Readmitted**	
		30 days	**180 days**	**30 days**	**180 days**
TOTAL	12586	807	3108	0.06411886	0.24694105
Age					
0-3	3	0	1	0.00%	33.33%
4-12	226	2	26	0.88%	11.50%
13-17	655	25	133	3.82%	20.31%
18-20	539	30	134	5.57%	24.86%
21-64	10667	736	2759	6.90%	25.86%
65-74	262	12	38	4.58%	14.50%
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Female	6078	409	1515	6.73%	24.93%
Male	6492	393	1585	6.05%	24.41%
Gender Not Available	16	5	8	31.25%	50.00%

Race					
American Indian/ Alaska Native	271	10	67	3.69%	24.72%
Asian	329	19	89	5.78%	27.05%
Black/African American	1026	113	308	11.01%	30.02%
Hawaiian/Pacific Islander	25	0	6	0.00%	24.00%
White	8238	540	2165	6.55%	26.28%
Hispanic*					
More than one race	502	54	147	10.76%	29.28%
Race Not Available	2195	71	326	3.23%	14.85%

Hispanic/Latino Origin					
Hispanic/Latino Origin	558	34	131	6.09%	23.48%
Non Hispanic/Latino	8552	646	2341	7.55%	27.37%
Hispanic/Latino Origin Not Available	3476	127	636	3.65%	18.30%

1. Does this table include readmission from state psychiatric hospitals? ☑ Yes ☐ No

2. Are Forensic Patients Included? ☐ Yes ☑ No

Comments on Data: Includes state hospital and CLIP facilities, evaluation and treatment centers, and community hospitals.

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

ISSUE:

#3) Within 30 days, the State shall submit to CMHS further detail regarding the use and development of evidence-base practices (EBP's).

RESPONSE:

Please see narrative related to CHILD Plan, issue #1 above.

However, to expand upon the state's support of EBP's and workforce development, MHD is utilizing MHBG funding to provide Trauma Focused Cognitive Behavioral Therapy, which has been proven to hold the greatest benefit to the populations we serve. It is based on a primary diagnosis of PTSD and Acute Stress Reaction.

MHD is going to fund training and certification for provider staff who are Master's level over the next two years, ensuring geographical diversity by targeting a variety of locations through out the state.

This program also allows for certified trainers to train others. Additionally, it is sustainable as the services provided are covered in our State Plan.

ISSUE:

#4) Within 30 days, the State shall submit to CMHS numerators and denominators for the Criterion 2 NOM: Increased Access to Services.

RESPONSE:

Goal 1: Increase Access to Services – Children and youth

Individuals have access to a system of comprehensive and integrated community based services.

Objective 1: Provide community support services for children and youth

Performance Indicator: Regional Support Networks will maintain a percentage of at least 1% of children in the general population who received mental health services. **(URS Table 2a)**

(The number of children/youth (0-17) who received community outpatient mental health services in given FY *over* the number of children/youth (0-17) in Washington State general population in the same given FY)

2004: 2.6% (Achieved) 39,041/ 1,522,071
2005: Not available at this time
2006: 2.6% (Planned)

Objective 2: Assure seamless discharge from inpatient services

***Performance Indicator*:** Regional Support Networks will maintain a percentage over 30% of children and youth who received outpatient services within 7 days after being discharged from an inpatient setting.

(The number of children/youth who were discharged from a state or community hospital, CLIP, or Evaluation and Treatment Center who were seen in outpatient services in a given FY 7 days following discharge *over* the number of children/youth discharged in the same given FY.)

2004: 59.3% (Achieved) 657/ 1107
2005: Not available at this time
2006: 47% (Planned)

***Performance Indicator*:** Regional Support Networks will maintain a percentage over 40% of children and youth who received outpatient services within 30 days after being discharged from an inpatient setting.

(The number of children/youth who were discharged from a state or community hospital or Evaluation and Treatment Center who were seen in outpatient services 30 days following discharge in a given FY *over* the number of children/youth discharged in the same given FY.)

2004: 73.3% (Achieved)
2005: Not available at this time
2006: 56.5% (Planned)

Objective 3: Improve access to services for ethnic minority children and youth

Performance Indicator: Regional Support Networks will maintain a statewide penetration rate of at least 25% for ethnic minority children who received publicly funded outpatient mental health services. **(Basic Tables 2a and b)**

(The number of ethnic minority children/youth served in community mental health outpatient services in a given FY *over* the number of children/youth served in community mental health outpatient services in the same given FY.)

2004: 36.7 % (Achieved) 14,348/ 39,144
2005: Not available at this time
2006: 35.5% (Planned)

Objective 4: Improve access to services for American Indian children and youth

Performance Indicator: Regional Support Networks will maintain a statewide penetration rate of at least 3.5% for American Indian children and youth who received publicly funded outpatient mental health services. **(Basic Table 2a and b)**

(The number of American Indian children/youth served in community mental health outpatient services in a given FY *over* the number of children/youth served in community mental health outpatient services in the same given FY.)

2004: 3.6% (Achieved) 1,439/ 39,545
2005: Not available at this time
2006: 4.1% (Planned)

ISSUE:

#5) Within 30 days, the State shall submit to CMHS a description of education, substance abuse and IDEA services for children with SED.

RESPONSE:

The Office of the Superintendent of Public Instruction (OSPI), Special Education Section, maintains a positive working relationship with the Mental Health Division Headquarters in the Department of Social and Health Services. A contractual agreement exists between OSPI and DSHS which includes a sub-contract specific to the Mental Health Division. The contract details the expectations with regard to access to and coordination of services for children with SED who are identified in relation to the special education needs of the child. The 296 independent school districts work cooperatively with the local Regional Support Network. The school districts refer children with special education needs to the RSN when there is a concern about the emotional needs of the child. Access to substance abuse services is coordinated in the same manner.

The Mental Health Division actively works in coordination with the Division of Alcohol and Substance Abuse to provide community education, to enhance workforce development efforts, and to ensure appropriate information is disseminated concerning appropriate access to the public mental health system. A co-facilitated training is provided regularly for counselors participating in a forty hour training on specialized services for children with co-occurring mental health and substance abuse treatment needs. Staff from DASA and MHD delivers a joint presentation during the training which is held on a recurrent basis throughout the year and is available without charge to individuals employed by community mental health agencies and agencies providing substance abuse services.

DASA was recently awarded a System Improvement Grant through SAMHSA focusing on prevention early identification efforts. MHD expects to be an active and primary participant in the work related to the grant.

ISSUE:

#6) Within 30 days, the State shall submit to CMHS services for children with SED who are homeless or live in rural areas.

RESPONSE:

Outreach to children and adolescents with SED who are homeless are generally provided by the adult mental health system through the PATH Program. Older adolescents coming out of the juvenile corrections system are linked to needed services.

ISSUE:

#7) Within 30 days, the State shall submit to CMHS a description of the State's financial and staffing resources.

RESPONSE:

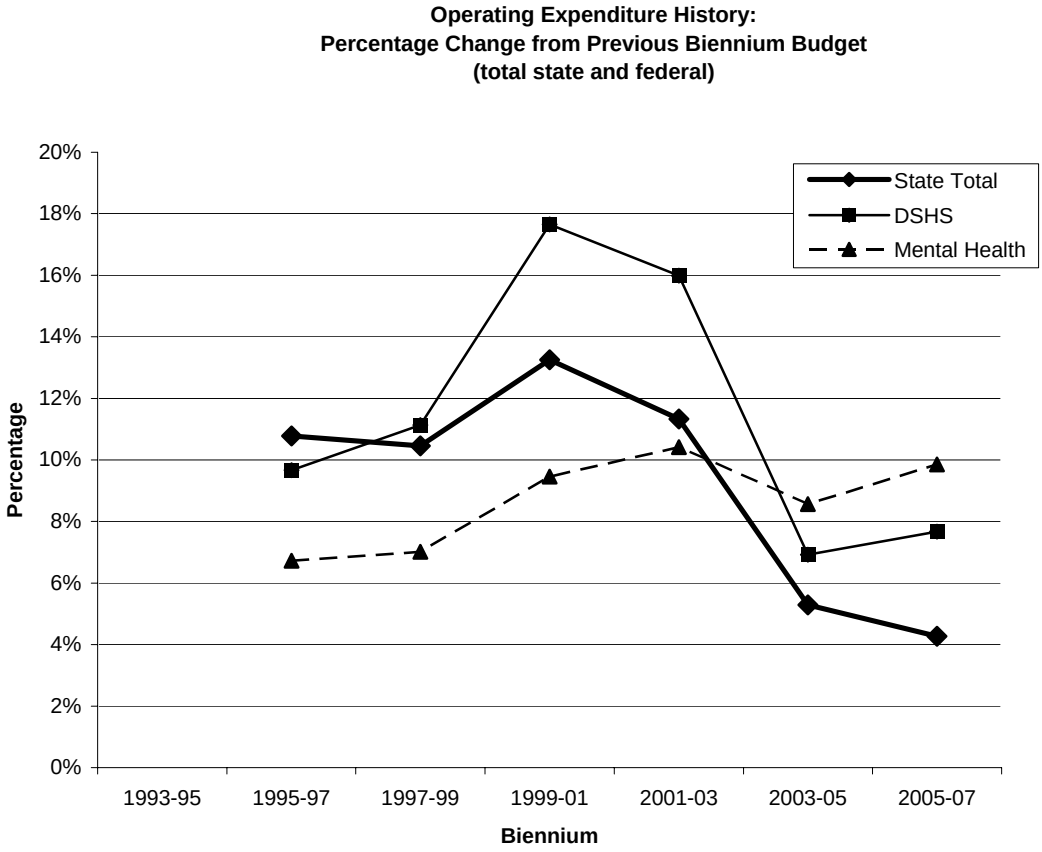
The MHD employees approximately 65 persons at headquarters and nearly1,700 persons at the state hospitals.

In the mid-1990s, Washington was granted a Medicaid 1915b waiver through the Federal Health Care Financing Administration (HCFA), now CMS. The waiver permits the State to purchase both outpatient and inpatient mental health services through PIHPs administered by RSNs. The amount of funding allocated to each RSN is determined by a capitated formula. This formula was originally based primarily on Medicaid-eligible individuals, but, under a planned transition, the formula has been shifting to give greater consideration to mental illness prevalence factors.

Thus MHD is currently responsible for the administration of a statewide integrated managed mental healthcare program. In FY03, this included community mental health services to 126,867 individuals, with almost 30 percent of those served being children under the age of 18. During that period, community inpatient psychiatric services were provided to 8,444 individuals.

Washington utilizes a 2-year budget, with the beginning of the biennium's first fiscal year starting on July 1 of odd-numbered years. In April 2005, the Washington Legislature approved a FY06-07 biennium State budget totaling over $49 billion, with over $17 billion (more than a third) allocated to DSHS. Of the DSHS budget, MHD's biennium budget was established at $1.3 billion (approximately $686 million per year), or about 8 percent of the DSHS budget.

A review of the past several biennium budgets reveals that, since the 1993-95 biennium, the State's operational budget has increased by 69 percent, the DSHS budget by 90 percent, and the MHD budget by 60 percent. As shown in the graph below, relative to State and DSHS budgets, MHD has fared better in more recent budgets in terms of percentage increase from the budget level of the previous biennium.



source: data from the Legislative Evaluation and Accountability Program Committee, http://leap.leg.wa.gov/leap/oversight/index_finalh.asp; http://leap.leg.wa.gov/leap/Budget/detail/2005/o0507f.asp).

ISSUE:

#8) Within 30 days, the State shall submit to CMHS a description of the use of $1.5 million in block grant funds allocated for "other grant activities".

RESPONSE:

Of the estimated 8.4 million dollars awarded to Washington State, 5% (grant limit) stays at MHD for administrative costs. Of the *remaining* 95%, Washington Administrative Code requires 80% to be distributed to the RSNs. The other 20% (approximately 1.5 million) is utilized by MHD for selected activities. In determining which initiatives would be funded this year, MHD developed the following list of guiding principals against which all proposals would be measured. To be funded as part of the 20%, activities must:

1. Be in concert with the National Outcome Measures and fall within the parameters of the MHBG assurances and requirements;

2. Work in tandem with the Division's Strategic Plan which, has been updated in collaboration with the MHPAC to incorporate the ideals of "Achieving the Promise: Transforming Mental Health Care in America";

3. Hold meaningful and measurable outcomes that are in line with articulated consumer/family voice;

4. Link well to other resources and transformation activities;

5. Meet needs in the system that are not fulfilled elsewhere, allowing for minimal negative impact on other service agencies if funding is not approved; and

6. Align well with other Division initiatives or legislatively mandated expectations.

This year's "20%" is focused supporting the following areas:

- **Consumer, advocate, and family voice** driven and promoted activities
- **Vocational** initiatives that lead to meaningful employment
- **Residential** resources that promote safe and affordable housing
- **Tribal** supports that improve infrastructure and services to tribal communities
- **MHPAC** resources that ensure consumer participation continues to increase and that state-wide diversity is represented
- **Data Development** to validate success our areas for improvement

The primary ways in which these focused areas will be supported include:

- **Conferences** such as those for co-occurring disorders, behavioral healthcare, foster care, early intervention, ethic minorities, and youth/parent advocacy.
- **Trainings** for issues or populations such as disasters, assisting consumer's in applying for Medicaid, increasing housing access, implementation of evidence–based practices, targeted trainings for geriatric specialists, ethnic minority specialist, chemical dependency specialists, older adults, ombuds, and peer support counselors.
- **Research and data collection** on such things as evidence–based practices, consumer satisfaction, club houses, and co-occurring disorders.

STATE DESIGNEE:_____DATE:_____
Amy Besel, Program Manager/Block Grant Planner

MHPAC DESIGNEE:_____DATE:_____
Joann Freimund, Chair MHPAC